Documenting Medical Necessity for Inpatient Psychiatric Services

SEPTEMBER 2024

PRESENTED BY

CalMHSA & Acentra Health

CalMHSA: A Brief Introduction

- California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority that provides California counties an independent administrative and fiscal structure for collaborative partnerships.

- CalMHSA develops strategies and programs that aim to transform community mental health, create cross-county innovations, and is dedicated to addressing equity to better meet the needs of our most vulnerable populations.

CalMHSA: A Brief Introduction (continued)

- In May 2022, CalMHSA launched its Inpatient Psychiatric Hospitalization Concurrent Review and Authorization program in collaboration with county Mental Health Plans (MHPs) and Acentra Health (formerly known as Kepro), with the goal of consolidating disparate processes into a centralized workflow.

- At this time, 24 MHPs across the state are participating, with Acentra Health conducting concurrent reviews on their behalf via participation agreements with CalMHSA.

- Acentra Health follows all the concurrent review and authorization requirements outlined in the Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 22-017.

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Learning Objectives

1. Identify key components of medical necessity in clinical documentation
2. Recognize common documentation pitfalls and apply strategies to avoid them
3. Implement best practices for effective documentation in clinical settings
4. Differentiate between acute days and administrative days in the context of medical documentation and billing

Our goal is to help hospital providers ensure documentation clearly establishes medical necessity

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Understanding Medical Necessity

- For individuals *21 years of age and older*, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain[1].
- For individuals *under 21 years of age*, a service is medically necessary if the service is needed to correct and ameliorate mental illness and conditions[2]. Services need not be curative or completely restorative to ameliorate a mental health condition.
  - Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as Early and Periodic Screening, Diagnostic and Treatment[3].

[1] WIC sec. 14184.402(a)
[2] 42 CFR 1396d(r)(5)
[3] EPSDT Coverage Guide (www.medicaid.gov)

Understanding Medical Necessity (continued)

- As of September 2024, DHCS continues to require hospitals to utilize the "ICD 10 Inpatient Diagnosis Codes and Descriptions" list (Enclosure 1) as outlined in DHSC BHIN 20-043 when requesting authorization/payment for inpatient services.

- Additionally, for concurrent review and authorization of inpatient psychiatric services, DHCS continues to follow the medical necessity criteria outlined in the California Code of Regulations (CCR) Title 9, Chapter 11, Section 1820.205.

Understanding Medical Necessity (continued)

- Clearly establishing medical necessity in clinical documentation ensures compliance and helps avoid denial/delays related to reimbursement for psychiatric inpatient services provided.

MD progress notes along with other supporting documentation (nursing notes, social worker notes) must clearly justify the necessity of inpatient care for each day, demonstrating why the patient cannot be safely managed at a lower level of care.

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Avoiding Common Documentation Pitfalls

Common Pitfall	Solution
Vague statements (For example, “Patient cannot be treated at a lower level of care.”)	Provide *specific* reasons and examples the person cannot be safely treated at a lower level of care. What are you seeing as the treating provider? What are your concerns if the person were to be discharged? How is what you are seeing different than how the person typically operates in the world? For example: "The patient cannot be treated at a lower level of care due to severe depression with persistent suicidal ideation, a specific plan, and intent. Despite inpatient interventions, their condition has not improved, requiring 24-hour supervision for safety. The patient also has significant functional impairments, such as neglecting personal hygiene and refusing to eat, necessitating intensive therapeutic support and medical monitoring.”

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Avoiding Common Documentation Pitfalls (continued)

Common Pitfall	Solution
Lack of justification for inpatient care/No explanation of why a lower level of care could be sufficient	Clearly articulate why an inpatient level of care is sufficient. This should be more than something such as ”Patient is responding to internal stimuli”. Many people live their daily lives outside of an inpatient setting while responding to internal stimuli and so that alone does not establish that medical necessity has been met for an acute inpatient day. The progress note must explain how you believe the person’s safety, or the safety of others, could be negatively impacted should they be released to a lower level of care. For example, “Patient is responding to internal stimuli. Reports hearing voices commanding self-harm. Recently attempted to follow these commands. High risk of self-injury or re-hospitalization if released.”
Repeated/copy and pasted notes that focus on how the patient presented on day 1 or previous days	Ensure that you are speaking to the patient’s current presentation and progress as of the day they are being seen vs. repeating the same content from the admission note/psychiatric evaluation.

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Avoiding Common Documentation Pitfalls (continued)

Pitfall	Solution
Incomplete or minimal Risk Assessment	Ensure comprehensive risk assessments are conducted and documented for each patient. Include specific details about any immediate safety concerns, behaviors, and potential risks to provide a clear justification for ongoing inpatient care as this can help support progress notes by physicians, nurses and social workers.
Not clearly documenting how the patient's condition impairs their ability to function in daily life, such as work, school, or social interactions.	Include detailed descriptions of how the patient's condition would negatively impact their daily functioning and safety of themselves and/or others if they were to longer be in an inpatient setting. Provide specific examples and observations that illustrate the severity of impairment and/or the safety concerns.

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Avoiding Common Documentation Pitfalls (continued)

Pitfall	Solution
"Patient is at baseline"	Generally, if an individual is "at baseline" that means they could potentially be treated at a lower level of care. To avoid a denial due to lack of medical necessity, it is important to clarify why the individual continues to require an inpatient level of care despite the perspective that they are at baseline. For example: “Patient is at baseline. However, they need to remain at an inpatient level of care because of their severe psychotic symptoms, including auditory hallucinations commanding self-harm, which require intensive monitoring and medication adjustments that are not feasible at a lower level of care” Or, “Patient is at baseline. However, they need to remain at an inpatient level of care because of their ongoing suicidal ideation with a specific plan and intent, which requires close monitoring and immediate intervention that cannot be provided at a lower level of care”

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Avoiding Common Documentation Pitfalls (continued)

Pitfall	Solution
"Patient is stable, eating all meals, attending all groups. There are no medication changes. Patient awaiting placement."	Assuming all BHIN 22-017 administrative day documentation requirements are met, a progress note such as this would meet the requirements for an administrative day. However, hospitals sometimes submit a note such as this but request an acute day, despite the progress notes not justifying ongoing acute needs. If a patient is stable and awaiting placement, it should be billed as an administrative day, provided documentation meets requirements. If the hospital believes the patient still qualifies for acute care while they are awaiting placement, this must be clearly indicated in the progress note. For example: "Patient is clinically ready for discharge but is awaiting appropriate placement. While awaiting placement, the patient continues to exhibit a need for acute care support as evidenced by [specific symptoms, e.g., severe agitation, intermittent suicidal ideation, self-harm behaviors, frequent aggressive outbursts, etc.]. These symptoms present significant safety concerns and require continuous monitoring and intervention that cannot be safely managed in a lower level of care."

Best Practices for Ensuring Comprehensive Documentation

- **Be Specific:** Describe symptoms, behaviors, and treatment responses in detail so that a reviewer gets a clear sense of why an inpatient level of care is most appropriate.
- **Be Consistent:** Ensure all parts of the documentation are consistent and support the necessity for inpatient care vs. a lower level of care.
- **Be Proactive:** Anticipate questions from reviewers and address them in your documentation. The reviewer does not know everything you know about the patient and why you feel the inpatient setting is more appropriate than a lower level of care.

Administrative Days

- ***Administrative Day Services*** can be claimed when a beneficiary no longer meets medical necessity for acute psychiatric hospital services and has been stabilized as much as possible in this setting but has not yet been accepted for placement at a non-acute residential treatment facility.
  - *Administrative Days are only applicable when attempts are being made to place individual in ***a non-acute residential facility*** (not just any facility being explored).
- The hospital cannot continue to request reimbursement for an “acute” day solely because a patient is utilizing the hospital’s/unit’s resources while awaiting discharge.

Administrative Days

- Acentra Health, as the vendor who is conducting concurrent review and authorization on behalf of participating California Counties, must follow the requirements outlined within BHIN 22-017.

- Acentra Health cannot and does not create their own rules regarding how administrative days are authorized or how much the state or counties reimburse for administrative days.

Questions?

Please feel free to submit any questions related to this training to CalMHSA at: managedcare@calmhsa.org

For questions related to authorization decisions, please reach out to Acentra Monday through Friday between 8am and 6pm PT at: Phone (866) 449-2737 or CAReviews@Acentra.com

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Thank You

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